

assigned vehicles. This resulted in a decrease of the amount of training required for medics to maintain a high level of medical proficiency.

[0010] In the study group, there were eight medics with two assigned to each company. One of the medics per pair of companies was a senior medic, and the other three were combat medics. In all but two instances the medics were left to their own devices when it came to the initial triage and treatments of soldiers in the training environments. In the other two instances the soldiers were evacuated immediately without the required field medical cards. In the rest of the cases reviewed, soldiers received inadequate medical treatment and were returned to duty until the unit or element returned to home station; the time on duty after return ranged from 24 hours up to 30 days. Upon return to home station, soldiers were then re-screened and treated as appropriate. In addition in all 40 of the cases that were screened for sick call in the field environment none of the required information was collected at the initial point of care nor were the medical supplies (Class VIII) accounted for in these treatments. During each of the training exercises, soldiers were each issued MILES casualty cards. When a soldier becomes injured through the training simulation, for example, he would read the MILES cards and present the medic with the symptoms listed on the cards. The medics were then responsible for the triage and treatment of the soldiers as necessary and as appropriate. The DD Form 1380 encounter was then documented on a Department of Defense 1380 Field Medical Card (or DD Form 1380). Approximately 8-20 personnel from each company became casualties depending on the scenarios. By the time the casualties reached the Level I Battalion Aid station, approximately 50% of the casualties had varying levels of treatment and approximately 10% had the required DD Form 1380 and 50% of those had the required information filled in on the Field Medical Card. At the battalion aid station the medics and providers recreated the missing field medical cards and filled in the missing treatments but in most cases lacked the necessary information to complete the initial encounter information due to lack of knowledge of the circumstances surrounding the injuries.

[0011] The last environment studied was the deployed state, which is when units are deployed to an operational environment either in the United States or in foreign countries. This part of the study was conducted using practical experience and interviews and review of medical information. In this environment, the medics are responsible for primary triage and treatment of soldiers for battle injuries, non-battle injuries, disease, psychological and sick call. The medics have limited resources and are generally left to their own devices to maintain unit medical readiness and treatment during operations other than war such as humanitarian missions and peace keeping operations. They are also required to conduct triage and treatment of soldiers during high intensity conflicts and acts of war. During these deployments, medics were provided little to no communications at all. Of the three cases reviewed: one soldier received combat related injuries, one soldier was evacuated due to stress related issues, and the third soldier had a dermatological condition that was treated and the soldier returned to duty. Of the three cases, the soldier that had combat related injuries received lifesaving treatment and was evacuated, the encounter was documented on a small piece of paper which upon review of the health record showed that it was lost and the soldier had to be re-screened and the treatments had to

be estimated. In case number two, the soldier was evacuated and the required encounter was not documented prior to evacuation. In the third case, the soldier was treated and returned to duty. The required information was not documented, a follow-up was scheduled, and the initial treatment was re-initiated and documented at that time.

[0012] The required training to maintain medical skills proficiency is either not being conducted or is inadequate to provide the required skill sets for the combat medics. The initial training provided to combat medics is insufficient to prepare them to conduct sick call at the unit level and in field environments. The required information is not being adequately collected or documented at the point of care and point of injury possibly due to insufficient emphasis being put on the requirement or due to the time it takes to document an encounter. Forty medics were provided various combat injury scenarios and completed the required elements on a field medical card. It took the forty medics an average of 3-5 minutes to fill in the initial encounter. This could have a negative impact on the required lifesaving treatment of combat injuries especially during a mass casualty scenario. The lack of documentation of the treatment at the initial point of treatment could also cause unnecessary administration of additional medications, thus causing clinical errors after initial triage. Providers would be more likely to capture this information at the point of care/point of injury if there could be an impact on the time it takes to document the encounter on the field medical card. During both the training and deployed environments, medics had little to no communications available to them to request resupply and had to rely on a supply request written on a notepad. In some cases, the medics did not get re-supplied until returning to their respective home stations. If medics were provided organic communications, they could have immediate access to more experienced providers and could then provide better medical care in the deployed environment as well as provide immediate information for medical reporting which is important for not only clinical treatment, command and control but also resupply of medical supplies such as class VIII medical supplies. NOTE TO INVENTOR—What are class VIII medical supplies?

[0013] An analysis of medical reporting and documentation was conducted through practical experience, review of outpatient health records, interviews and review of literature. On average, 25,000 pages of documents and forms are created for inclusion in Department of Defense (DOD) medical records every day. Requests for service, such as sick call, are a daily occurrence; efforts to provide that service promptly were once a struggle. Medical reporting is currently accomplished by collecting log sheets and collating them from the referring units and questionnaires completed by both referring and consulting doctors. See "Presidential Advisory Committee on Gulf War Veterans' Illness Final Report, 1996".

[0014] A review of a set of 5000 outpatient health records for active duty soldiers provided a set of 492 records that were for combat related injuries. Of those 492 records, there was just one DD Form 1380 present, which indicates that information was getting lost or not capture at all. In accordance with AR (Army Regulation) 40-66, the medical record and quality assurance administration that requires the DD Form 1380, all health care information collected is required to be maintained in the health care records. The Medical